STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555099	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakewood Healthcare Center	12023 Lakewood Blvd. Downey, CA 90242

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow the physician's order for one of three sampled residents (Resident 5), who had an order for one-to-one monitoring ([1:1] assigning a dedicated staff member to continuously observe and monitor a single resident to ensure their safety and well-being).This failure placed the resident at risk of not receiving the care and services necessary to maintain the residents' highest practicable physical, mental and psychosocial well-being.Findings:During a review of Resident 5's admission Record, the admission Record indicated Resident 5 was originally admitted to the facility on [DATE] and was readmitted on [DATE]. Resident 5's diagnoses included polyarthritis (a medical condition characterized by inflammation and pain in multiple joints) and unspecified dementia (a progressive state of decline in mental abilities), unspecified severity with other behavioral disturbance.During a review of Resident 5's Minimum Data Set ([MDS], a resident assessment tool), dated 5/19/2025, the MDS indicated Resident 5 had severe cognitive impairment. The MDS indicated Resident 5 required partial/moderate assistance (helper does less than half of the effort) for Activities of Daily Living (ADLs) such as eating and oral hygiene.During a review of Resident 5's Order Summary Report for 7/2025, the Order Summary Report indicated a physician order dated 7/22/2025 for Resident 5 to have 1:1 monitoring (reason not specified). During a review of Resident 5's care plan titled Resident to resident altercation, patient hit another resident. dated 7/28/2025, the interventions indicated to provide safe and stress free environment, observe and monitor for any changes in behavior for 72 hours and notify the physician (PCP) for any significant changes, monitor episode of emotional distress for 3 days, 1:1 monitoring s/p (post) resident to resident altercation and 3o minutes monitoring every shift for 3 days.During a review of Resident 5's Order Summary Report for 7/2025, the Order Summary Report indicated a physician order dated 7/28/2025 for Resident 5 to have 1:1 monitoring s/p resident to resident altercation and 30-minute monitoring every shift for 3 days.During a concurrent interview and record review on 7/31/2025 at 12:23 p.m. with Registered Nurse (RN) 3, Resident 5's physician order dated 7/22/2025 and 7/28/2025, were reviewed. RN 3 stated Resident 5 had an order for 1:1 monitoring on 7/22/2025 and an order dated 7/28/2025 which indicated 1:1 monitoring s/p resident to resident altercation and 30-minute monitoring every shift for 3 days. RN 3 stated Charge Nurses and the Director of Staff Development (DSD) should ensure all residents with orders for monitoring for 1:1 should have an assigned staff.During an interview on 7/31/2025 at 12:54 p.m. with the DSD, the DSD stated the facility did not assign staff to do 1:1 monitoring on Resident 5 on 7/26/2025 and 7/27/2025. The DSD stated Resident 5's progress notes did not indicate if Resident 5's behaviors were evaluated or if the PCP was called to clarify if the 1:1 order was still needed.During a concurrent interview and record review on 7/31/2025 at 1:24 p.m. with the Director of Nursing (DON), Resident 5's Order Summary Report, dated 7/28/2025, were reviewed. The DON stated residents on 1:1 monitoring should be reevaluated after 24 or 72 hours for any safety concerns and re-evaluate if the 1:1 monitoring is still needed or not. The DON stated Charge Nurses should ensure residents with a 1:1 order was assigned to staff every shift. The DON stated the facility had no policy indicating that 1:1 monitoring orders should automatically end after 72 hours.During an interview on 8/1/2025 at 1:34 p.m. with the DON, the DON stated the facility staff should have reassessed Resident 5's behavior for any safety concerns and called the resident's PCP to update and verify if Resident 5 would still require the 1:1 monitoring order.During a review of the facility's policy and procedure (P&P) titled, MR29 Physician Orders, dated 12/28/2022, the P&P indicated, the licensed nurse should confirm that physician orders are clear, complete, and accurate as needed. The P&P indicated treatment orders (essential for the proper care and management of residents, including medication administration, dietary restrictions, and other medical interventions tailored to the resident's specific needs and are crucial for healthcare providers to communicate these clearly and consistently to maintain the quality of care and compliance with medical standards) should include the duration of order (when appropriate).